

STATE OF NEW YORK

## **UNEMPLOYMENT INSURANCE APPEAL BOARD**

PO Box 15126 Albany NY 12212-5126

## **DECISION OF THE BOARD**

Mailed and Filed: APRIL 26, 2023

IN THE MATTER OF:

Appeal Board No. 628200

PRESENT: MICHAEL T. GREASON, MEMBER

The Department of Labor issued the initial determination disqualifying the claimant from receiving benefits, effective July 30, 2022, on the basis that the claimant lost employment through misconduct in connection with that employment and holding that the wages paid to the claimant by CITIZENS OPTIONS UNLIMITED prior to July 30, 2022 cannot be used toward the establishment of a claim for benefits. The claimant requested a hearing.

The Administrative Law Judge held telephone conference hearings at which all parties were accorded a full opportunity to be heard and at which testimony was taken. There were appearances by the claimant and on behalf of the employer. By decision filed February 7, 2023 (), the Administrative Law Judge sustained the initial determination.

The claimant appealed the Judge's decision to the Appeal Board.

Based on the record and testimony in this case, the Board makes the following

FINDINGS OF FACT: The claimant was employed full-time for more than five and a half years by the employer nonprofit organization that provides services for individuals with intellectual and other developmental

disabilities. At the time of her separation from employment, the claimant was a live-in house manager in the employer's residential program. The residence the claimant lived in and managed, included her apartment and two resident bedrooms on the second floor, four resident bedrooms, a kitchen, living room, and den on the first floor, and a finished basement common area with a pantry

and gaming/exercise room and a T.V. All staff signed a code of conduct which outlined their responsibilities with respect to ensuring the safety of "supported individuals" (residents in the program). As house manager, the claimant was responsible for ensuring that each resident's plan of protective oversight and safety was followed, and that her directives were carried out.

On or about April 20, 2022, the claimant instructed a staff member to take one of the residents, "N," with her and the rest of a group when she left the residence. After giving this instruction, the claimant left to conduct other employer business. Sometime later, N telephoned his mother and informed her that he was alone in the house. It was not part of N's safety program to be allowed to stay in the house by himself. The employer conducted an in-house investigation, and an investigation was conducted by the Center for Justice, which determined that there was a substantiated incident of neglect in connection with N being left alone in the residence.

After the April 2022 incident, the claimant and other staff were told that such an occurrence could not happen again. The claimant was aware that leaving an individual alone who was not supposed to be left alone, was detrimental to the employer's interests, and to the safety of the individual. Further, as a result of the incident, rules and procedures were reviewed, and a system was put in place requiring the last staff member in the house to perform a "sweep of the house before leaving out with the guys." This plan was put in place to ensure that no resident who had a safety plan requiring supervision at all times, would be left alone in the house again. The claimant both presented, and received, the training on this new floor sweep plan, which also included that each resident's individual room must be checked, and that calling out names was not sufficient because some of the residents wear headphones.

On the morning of July 14, 2022, the claimant instructed the assistant house manager to take a resident, "C", with her when she left that morning, to take him for a ride. C is an individual who has autism, ADHD, impulse control disorder, generalized anxiety disorder, a history of suicidal ideations, and an excessive food drive. C's plan of protective oversight required that he not be left alone for safety reasons. The claimant then dispensed required medication, and the staff-other than the claimant and residents left. The claimant prepared to take another resident, MM, to a day program. Before leaving, the claimant checked the residents' bedrooms on the first and second floor, and did a visual sweep of the first floor of the house. The claimant did not check the finished basement before she left the residence. After the

claimant dropped MM at his day program, she drove to another residence she was managing that day. Later, another staff member called the claimant's main residence, and C answered the phone, reporting that he was alone in the house. It was later learned that C had not gone with staff as the claimant had directed, but was in the house, in the basement where he tended to go, when the claimant performed the "sweep" as the last staff member to leave the house.

The employer conducted an investigation, as did the Center for Justice, which again found that a substantiated act of neglect. The employer discharged the claimant on July 29, 2022, effective that same day.

OPINION: The evidence establishes that the claimant was discharged following the July 14, 2022 incident when she left a residence for the intellectually and developmentally disabled, without doing a check of the whole house as required by the employer's protocol. The claimant's failure resulted in a disabled individual under the employer's care being left alone in the residence. We find that the claimant's conduct disregarded the employer's safety plan for the residence, as well as the safety and care plan for the individual, and was misconduct under the Labor Law.

Even if we were to credit the claimant's contention that she was not informed that the April 20, 2022 incident was substantiated by the Center for Justice, that fact would not be determinative. Notwithstanding the

Center's finding, the April 2022 incident itself is significant since it was the impetus for the "floor sweep"

protocol that the employer put into effect to ensure that residents who are not supposed to be alone, are not left behind when all staff leave the house. The claimant was aware of the incident, the protocol, and the reason it was implemented. Further, it is not dispositive that the claimant was not the last staff member to leave the residence on April 20, 2022. Regardless of whether the claimant was directly responsible for the earlier incident, it is not disputed that her own actions, or failures to act, on July 14, 2022 resulted in an at-risk individual, for whom she was responsible, being left alone when his safety plan specifically directed that it was not safe for him to be unsupervised.

We are not persuaded by the claimant's contention that she was not supposed to "sweep" the entire house, but only had to check the bedrooms. The claimant was

aware that the sweep plan was put into effect because a resident who was not supposed to be left alone in the house, had been left alone in the house in April, and that the protocol was put in place to ensure that such an oversight did not happen again. Further, the sweep plan itself provides that the entire house is to be checked, not just the bedrooms. The fact that the claimant had instructed another staff member to take C with her is not dispositive, since the claimant was aware that on at least one prior occasion, a staff member did not follow her directive, resulting in an individual being left alone and unsupervised. Moreover, the claimant knew that as a result of that prior incident, a new plan was in place to ensure that a similar incident would not happen again, yet failed to follow that protocol.

This case is akin to multiple cases in which school bus drivers, or drivers of transport vehicles for disabled individuals, failed to check their vehicles to ensure that no individuals were left on the bus after drop-off. In those cases, the Board has found misconduct, opining that the degree of care expected of claimants is commensurate with the potential for harm, and that the claimants' dereliction of duty resulted in special needs individuals being left alone, and was misconduct. See, generally, Appeal Board Nos. 561236, 559028A, and 546431. See also, Matter of Cedrone, 69 AC3d 1251 (3rd Dept, 2010), in which the court found that the conduct of a claimant who left a child in a classroom during a fire alarm, in violation of the employer's safety protocol, "was not simply negligent, but was a violation of an important safety policy and was clearly adverse to the facility's interests," and was therefore disqualifying.

Here, the claimant was responsible for ensuring the safety of the disabled residents, and in particular for ensuring that no individual was left alone at the residence when he should not be. Of particular significance is the fact that the individual left alone had multiple intellectual and developmental disabilities and disorders, and that he, according to the claimant's testimony, tended to go to the basement. As a common area of the house, this area was subject to the sweep that should have been performed by the claimant, but that she neglected to do. We find that the claimant's failure to follow procedure was a failure to exercise the degree of care required, was a violation of the employer's reasonable and known protocol, and was detrimental to the employer and to individuals in the employer's care. Accordingly we find that the claimant's failure constituted misconduct for unemployment insurance purposes, and we conclude that the claimant was separated from employment under disqualifying circumstances.

DECISION: The decision of the Administrative Law Judge is affirmed.

The initial determination, disqualifying the claimant from receiving benefits, effective July 30, 2022, on the basis that the claimant lost employment through misconduct in connection with that employment and holding that the wages paid to the claimant by prior to July 30, 2022 cannot be used toward the establishment of a claim for benefits, is sustained.

The claimant is denied benefits with respect to the issues decided herein.

MICHAEL T. GREASON, MEMBER